NOTICE: This form must be printed on 8 1/2" x 14" paper

NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION — ACTIVE EMPLOYEE GROUP

Division of Pension and Benefits, P.O. Box 299,Trenton, NJ 08625-0299 HA-0709-0904

1. EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Title (Jr., Sr., etc.) ☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

Street Address (Include Apartment #) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐

ZIP Code + 4 ☐☐☐☐☐ - ☐☐☐☐ Date of Birth (mm/dd/yy) ☐☐/☐☐/☐☐ Gender (M/F) ☐

Status:

☐ -Single ☐ -Married ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

Are you transferring from another SHBP participating employer? ☐ Yes ☐ No

(Area Code) Home Telephone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

If yes, name of employer: _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

☐ I wish to be covered under NJ PLUS.

Enter your NJ PLUS Primary Care Physician's ID# ☐☐☐☐☐☐☐☐☐☐☐☐

☐ I wish to be covered under an HMO.

_____ Name of HMO _____ HMO#

Enter your HMO Primary Care Physician's ID# ☐☐☐☐☐☐☐☐☐☐☐☐

☐ I wish to be covered under the Traditional Plan.

☐ I am changing medical plans only:

From _____ to _____

☐ I elect to waive medical coverage in any medical plan (see instructions).

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse ☐ Parent and Child(ren)

☐ Family ☐ Member and Domestic Partner (see instructions)

3. PRESCRIPTION DRUG COVERAGE — See note below

3a. EMPLOYEE SELECTION

☐ I wish to be covered by the Employee Prescription Drug Plan.

☐ I elect to waive Employee Prescription Drug Plan coverage.

3b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse ☐ Parent and Child(ren)

☐ Family ☐ Member and Domestic Partner (see instructions)

Note: Prescription Drug coverage is available to all State employees. Local/Educational employers must have elected to provide the SHBP Employee Prescription Drug Plan to employees as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide a separate drug plan, do not complete this selection. (If your Local/Educational employer does not provide any separate drug coverage, your SHBP medical plan will include a prescription drug benefit.)

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____ ☐

P _____ _____ _____

EMPLOYER CERTIFICATION

See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) ☐☐☐ Union Code (Rx) Only ☐☐

Location # (State Monthly and Local/Eduacational) ☐☐☐☐ - ☐☐

10/12 month employee (Enter "10" or "12") ☐☐

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence _____/_____/_____ (mm/dd/yy)

_____ Signature of Certifying Officer

_____ Telephone # Date Mailed

4. DEPENDENT INFORMATION - List only eligible dependents (see instructions on reverse).

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
☐ Spouse ☐ Domestic Partner								
Children								

5. TYPE OF ACTIVITY (complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (mm/dd/yy) _____

(Copy of Marriage Certificate required)

Former Name _____

☐ Domestic Partner - Date of Event (mm/dd/yy) _____

(Copy of Certificate of Domestic Partnership required)

☐ Birth of Child ☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

5b. DELETION OF SPOUSE OR DOMESTIC PARTNER

☐ Separation ☐ Divorce ☐ Death ☐ Termination of Domestic Partnership

Date of Event (mm/dd/yy) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only (Attach copy of supporting documentation)

(List former name) _____

☐ Change in Soc. Sec. # (Attach copy of Social Security card)

(List former Soc. Sec. #) _____

☐ Change in Birth Date (Attach copy of birth certificate)

(List name and correct date) _____

_____

☐ Other - give reason (i.e., address change, dependent returns from military service) _____

6. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities in the NJ PLUS and HMO plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ Employee Signature _____ Date Completed

INSTRUCTIONS FOR THE NJ STATE HEALTH BENEFITS PROGRAM APPLICATION
STATE AND LOCAL/EDUCATIONAL ACTIVE EMPLOYEE GROUP

- **To change your primary care physician** (PCP) with NJ PLUS or your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- **To enroll** for the first time complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b (if enrolling in an HMO or NJ PLUS be sure to list your primary care physician's identification number), 4 (listing all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3a and 3b (if prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if prescription drug coverage is provided by your employer), 4 (listing all eligible dependents), 5a, and 6.
- **To terminate/decline coverage** complete sections: 1, 2a and/or 3a (as applicable), and 6. (If you are eligible to waive coverage under the provisions of NJSA 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer.) If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 - MEDICAL COVERAGE

2a. Check only one box indicating the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage.

2b. If you are electing coverage, check the level of coverage desired.

DOMESTIC PARTNER: Domestic Partner coverage is available to State employees and to Local/Educational employees whose employer has adopted a resolution to participate in Chapter 246, P.L. 2003, The Domestic Partnership Act. A domestic partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, as a person of the same sex with whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for more information). If covering a domestic partner as a dependent, you must attach a photocopy of your *Certificate of Domestic Partnership* to this application.

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to State employees and to only Local/Educational employees whose employers have adopted a resolution to provide this coverage. If the Employee Prescription Drug Plan is provided by your employer:

3a. To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage.

3b. If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see “Domestic Partner” under 2b above).

NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 - DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b, and 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. An eligible domestic partner is an individual of the same-sex with whom you have entered into a domestic partnership (see note in instructions for Section 2, above). If you have listed a child that is an adopted child, foster child, stepchild, legal ward, or has a different last name than the employee, proof of dependency is required (contact your payroll/personnel representative for an *SHBP Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. For all dependents, include the NJ PLUS or HMO Primary Care Physician identification number. All dependents must have this information listed. Refer to the NJ PLUS or HMO directory or Web site for this information, or call the health plan directly. Plan Web site and phone number can be found on the *Comparison Summary Chart*.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 - TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and indicate the event date.

5b. If you are deleting a dependent spouse or domestic partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application to the SHBP. By signing this application the employer certifies that:

1) The employee is eligible;
2) The application is legible and completed in its entirety;
3) The employee's selected plans and coverage levels are appropriate;
4) The Employer Certification section is completed in its entirety; and
5) The information presented is true to the best of their knowledge.